Before Starting the CoC Application

You must submit all three of the following parts in order for us to consider your Consolidated Application complete:

1. the CoC Application,
2. the CoC Priority Listing, and
3. all the CoC's project applications that were either approved and ranked, or rejected.

As the Collaborative Applicant, you are responsible for reviewing the following:

1. The FY 2026 CoC Program Competition Notice of Funding Opportunity (NOFO) for specific application and program requirements.
2. The FY 2026 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.

Your CoC Must Approve the Consolidated Application before You Submit It
- 24 CFR 578.9 requires you to compile and submit the CoC Consolidated Application for the FY 2026 CoC Program Competition on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

1A. Continuum of Care (CoC) Identification

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

1A-1. CoC Name and Number: NY-522 - Jefferson, Lewis, St. Lawrence Counties CoC

1A-2. Collaborative Applicant Name: CARES of NY, Inc.

1A-3. CoC Designation: UFA

1A-4. HMIS Lead: CARES of NY, Inc.

1B. Coordination and Engagement–Accountable Structure and Participation

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

1B-1.	Accountable Structure and Participation.	

	In the chart below for the period from June 1, 2025 to May 31, 2026:
1.	select 'Yes' or 'No' in the chart below if the entity listed participated in CoC meetings or select 'Nonexistent' if the entity does not exist in your CoC's geographic area, and
2.	enter the number of persons on the board for each category where you answered 'Yes' in the Participated in CoC Meetings column.

You must click Save at the bottom of the form before entering the number of persons for each category where you answered 'Yes'.

	Entity	Participated in CoC Meetings	Number of Board Members
1.	Affordable Housing Developer(s)	Yes	1
2.	CDBG/HOME/ESG Entitlement Jurisdiction(s)	Yes	
3.	Certified Community Behavioral Health Clinic (CCBHC)	Yes	1
4.	Community Mental Health Center (CMHC)	Yes	
5.	Disability Advocate(s)	Yes	
6.	Disability Service Organization(s)	Yes	1
7.	Emergency Medical Services (EMS)/Crisis Response Team(s)	Yes	
8.	Employment Assistance Program(s) (e.g., Local Workforce Development, American Job Center)	Yes	
9.	Faith-based Organzation(s)	Yes	1
10.	Homeless or Formerly Homeless Person(s)	Yes	1
11.	Hospital(s)	No	
12.	Other Primary Healthcare Provider(s) (e.g., Federally Qualified Health Center, Healthcare for the Homeless)	No	
13.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	Yes	
14.	Law Enforcement	Yes	2
15.	Local Court Systems, Including Specialty Courts (e.g., Mental Health Court, Drug Court, Care Court)	No	
16.	Local Government Staff/Official(s)	Yes	3

17.	State Government Staff/Official(s)	Yes	2
18.	State or Local Elected Public Official(s)	Yes	3
19.	Local Jail(s)	No	
20.	Mental Health Service Organization(s)	Yes	
21.	Mental Illness Advocate(s)	Yes	1
22.	Organization(s) led by and serving people with disabilities	Yes	
23.	Other homeless subpopulation advocate(s)	Yes	
24.	Other nonprofit homeless assistance provider(s)	Yes	2
25.	Other social service provider(s)	No	
26.	Public Housing Agencies	No	
27.	Recovery Housing or Sober Living Provider(s)	Yes	
28.	School Administrators/Homeless Liaison(s)	No	
29.	School District(s)	No	
30.	Street Outreach Team(s)	Yes	
31.	Substance Abuse Advocate(s)	No	
32.	Substance Abuse Service Organization(s)	Yes	
33.	Universities	No	
34.	Veteran Serving Organization(s)	Yes	1
35.	Agencies Serving Survivors of Human Trafficking	Yes	
36.	Victim Service Provider(s)	Yes	
37.	Domestic Violence Advocate(s)	Yes	
38.	Other Victim Service Organization(s)	No	
39.	State Domestic Violence Coalition	No	
40.	State Sexual Assault Coalition	No	
41.	Youth Advocate(s)	Yes	
42.	Youth Homeless Organization(s)	No	
43.	Youth Service Provider(s)	Yes	
44.	Other Homeless Assistance Provider(s)	No	
45.	Local Business or Chamber of Commerce or a Member of a Business Improvement District	Yes	1
	Other: (limit 50 characters)		
46.			
47.			

1B-2.	Open Invitation for New Members.	

Describe your CoC's transparent process (e.g., communicated to the public on the CoC's website) to invite new members to join the CoC at least annually.

(limit 2,500 characters)

1) The CoC communicates the invitation process transparently and publicly to solicit new members to join the CoC by a) sharing the invitation and New Member application via the CoC's website and the Civic Roundtable platform, b) asking listserv recipients to forward invitations, c) announcements at full Membership meetings encouraging current members to invite others, and d) phone conversations with key systems partners focusing on the benefits and responsibilities of CoC membership. The Membership application is posted year-round on the CoC's website and accepted on a rolling basis. Additionally, to solicit new members to join the CoC, the CoC assesses current members and conducts targeted outreach. 2) The CoC ensures this invitation process occurs annually. Annually, the CoC Board assesses what organizations participate in CoC Membership, on the Board, and on Committees, and identifies missing stakeholders to engage to support community efforts to address homelessness. The Board creates an outreach plan in collaboration with the Collaborative Applicant. The CoC ensures effective communication by sharing invites/applications in a variety of electronic formats, including the CoC webpage, which is responsive to screen reader software and email listservs. The CoC has invited organizations serving specific communities experiencing homelessness such as mental health, substance use, youth, and domestic violence providers to become members by assessing sector representation at the Membership and Board levels through an annual Membership Assessment tool. [AG9.1]The tool was created to assess the current capacity of the Board and membership and to identify strengths and deficits. This tool informs outreach for open/new Board positions and the CoC uses this tool to match knowledge, skills, and abilities that are most needed in the community. As a result, the Salvation Army and Community Meals at Emmanuel Congregational Church are part of the Membership. Further, new members are encouraged to watch the recorded CoC 101 series that is posted to CoC webpage which provides a comprehensive overview of the CoC, its benefits and requirements to encourage participation on the Board and Membership.

1B-3.	CoC's Strategy to Solicit and Consider Opinions on Preventing and Ending Homelessness.	

Describe your CoC's transparent process (e.g., communicated to the public on the CoC's website) to solicit and consider opinions regarding the CoC's general performance, strategies, and priority setting process from a broad array of individuals and organizations that have knowledge of homelessness or an interest in preventing or ending homelessness in the CoC's geographic area.

(limit 2,500 characters)

A) CoC Strategy to Solicit and Consider Opinions on Preventing and Ending Homelessness - The Points North Housing Coalition CoC maintains a transparent, year-round process to gather and consider input on CoC performance, strategies, and priorities. Participation opportunities are publicly communicated through the CoC website, which includes membership information, meeting materials, an online submission form, and a recorded CoC 101 training series. Input is collected through Membership and committee meetings, community and funding forums, workshops, targeted outreach, virtual meetings and trainings, email listservs, the Civic Roundtable platform, and engagement with program participants. Stakeholder feedback is used to evaluate CoC performance, inform strategic planning, update priorities, and guide funding decisions. The Board and Planning Committee review input from community members, Membership meetings, committees, workshops, and funding forums. Recommendations are documented in meeting minutes, reviewed by committees as needed, and shared with the Board and Membership. Community workshops, including livestreamed and recorded options, support accessibility, transparency, and meaningful engagement. B) Broad Array of Individuals and Organizations Engaged in the Process - The Points North Housing Coalition CoC engages a diverse range of individuals and organizations with knowledge of or interest in preventing and ending homelessness. Participants include persons with lived experience, housing and homeless service providers, affordable housing organizations, local and county governments, law enforcement and parole representatives, faith-based organizations, and other community partners. The CoC maintains open membership and recruits participants year-round through its website, listservs, Membership meetings, invitations, and targeted outreach. Applications are accepted on a rolling basis, and organizations new to CoC funding are encouraged to participate. Through virtual and in-person engagement opportunities, accessible materials, electronic communications, and recorded trainings, the CoC ensures broad participation and diverse community input into local homelessness planning, strategies, and priorities.

1B-4.	Public Notification for Proposals from Organizations Not Previously Awarded CoC Program Funding.	

Describe your CoC's transparent process to accept and consider proposals from organizations that have not previously received CoC Program funding including faith-based organizations.

(limit 2,500 characters)

NY-522 maintains a transparent process for accepting and considering project proposals from both current recipients and organizations that have not previously received CoC Program funding, including faith-based organizations. The CoC publicly announces the local competition and funding opportunities through postings on the Collaborative Applicant's website, notices distributed through CoC membership and stakeholder email lists, Civic Roundtable communications, direct outreach to community organizations, and other public notifications. Application materials, eligibility requirements, submission instructions, competition timelines, and evaluation criteria are made available to all interested applicants. The CoC actively seeks proposals from organizations that are not currently receiving CoC Program funding. Competition materials explicitly state that organizations do not need to be current CoC Program recipients to apply. Information regarding available funding opportunities, eligible project types, and application requirements is shared publicly to promote broad participation from eligible organizations, including faith-based organizations. The CoC publicly communicates the process used to determine which projects will be included in the Priority Listing and submitted to HUD. The CoC's approved Rank and Review process, scoring criteria, threshold requirements, local priorities, and application materials are publicly available and communicated throughout the competition. New project applications are reviewed and scored using CoC-approved criteria that assess factors such as community need, alignment with HUD priorities and best practices, organizational capacity, project quality, and fiscal capacity. Funding recommendations are developed through the Rank and Review process and receive final approval through the CoC's governance structure. All applications received through the local competition are evaluated using the same published process and criteria, ensuring a fair, transparent, and non-discriminatory review process for existing recipients, new applicants, and faith-based organizations.

1B-5	Plan for Comprehensive Strategies for Reducing Homelessness.

Describe how your CoC will incorporate comprehensive strategies for reducing homelessness, including interventions in 42 U.S.C. 11386b(d) and other targeted projects for specific subpopulations, by providing a plan to address a gap in the CoC's current homelessness system.

(limit 2,500 characters)

PNHC has a plan for addressing gaps in the CoC's homeless system by utilizing a comprehensive data-driven planning process to identify and address gaps within the system. Gaps are identified through HMIS data analysis, HIC & PIT results, system performance, Board and Membership meetings, committee discussions, provider feedback, surveys, and outreach with community partners. These efforts have identified ongoing needs related to housing placement and retention for youth, survivors of DV, veterans, individuals with behavioral health needs, and households experiencing chronic homelessness. To address these gaps, PNHC will continue implementing proven strategies identified under 42 U.S.C. 11386b(d) The CoC will strengthen Coordinated Entry, increase landlord engagement, improve access to mainstream benefits, and support interventions for youth, veterans, survivors of DV, and individuals with MH & SUD. During the contract year, PNHC will work to increase permanent housing placements by 5%, increase housing retention rates by 5%, increase participation in Coordinated Entry by 10%, and reduce the average length of time households experience homelessness by 5%.
By the end of the first quarter, PNHC will complete a system-wide review of HMIS, PIT, HIC, and Coordinated Entry data to establish baseline measures and identify priority gaps. Quarterly data reviews will assess progress toward performance targets and identify needed system adjustments. By mid-year, the CoC will evaluate progress toward placement, retention, and Coordinated Entry goals and implement corrective actions as necessary. By the end of the contract year, PNHC will evaluate outcomes and use findings to inform future planning and resource allocation. Performance will be monitored through HMIS data quality reports and System Performance Measures, including housing outcomes, income growth, housing retention, and Coordinated Entry participation. PNHC will maintain a goal of at least 95% HMIS data completeness and accuracy across participating projects. Oversight will be provided by the Governance Committee, CoC Board, HMIS Lead, Coordinated Entry partners, and system committees, which will review progress, recommend adjustments, and ensure strategies remain responsive to community needs while reducing homelessness and increasing housing stability across all populations served.

1B-5a	Confirmation of Plan Coverage.

Select 'Yes' or 'No' in the chart below to indicate whether your narrative in question 1B-5 addresses the following aspects of your plan to address a gap in the CoC's current homelessness system.	
1. Identifies the gap, using data or stakeholder feedback	Yes
2. The strategy to address the needs of all relevant subpopulations	Yes
3. Sets quantifiable performance measures	Yes
4. Identifies timelines for the completion of specific tasks	Yes
5. Identifies specific funding sources for planned activities	Yes
6. An individual or body responsible for overseeing implementation of specific strategies	Yes

1C. Coordination and Engagement

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

1C-1.	**Treatment and Recovery Services—On-site Substance Use Treatment Availability.**	
	You must upload the List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment attachment to the 4A. Attachments Screen.	
	What percent of your TH/RRH/PSH projects have substance use treatment available on site?	33%

If you are a rural CoC, describe what substance use treatment is available in your CoC and how people you serve access those services.

(limit 2,500 characters)

Points North Housing Coalition (PNHC) is a rural CoC but has met/exceeded the 30% threshold for TH/RRH/PSH projects that provide on-site substance abuse services. An attachment has been provided to outline the breakdown of these services by project. Along with having access to the on-site services outlined in the attachment, participants have access to community-based treatment through established partnerships and referral relationships with Thrive Wellness and Recovery. Project participants are connected to substance use assessment, treatment, recovery support services, peer counseling, and community-based recovery programs through coordinated referrals. Providers work closely with these partners to ensure timely access to treatment and ongoing support for individuals with substance use disorders throughout the CoC's service area.

1C-1a. Treatment and Recovery Services—Outpatient Treatment for Mental Health and Substance Use Disorders.

Describe how your CoC partners with, or has projects that provide, outpatient treatment for mental health and substance use disorders with a range of appropriate levels of care, psychosocial interventions, medication management, suicide prevention, and recovery supports.

(limit 2,500 characters)

1.) The CoC works with both MH & SUD providers to assist program participants to receive both SUD & MH treatment with a range of levels of care, interventions, medication management, suicide prevention and recovery supports by a.) maintaining formal partnerships with behavioral health and recovery service providers throughout the CoC through signed and annually updated service agreements and participation in the CoC Membership. One example is the formal partnership with THRIVE Wellness and Recovery, Inc., which provides coordinated access to mental health treatment, substance use disorder services, crisis intervention, peer support services, and care coordination and recovery- focused interventions for individuals experiencing homelessness. Through this partnership providers can make direct referrals and coordinate service delivery to ensure participants have timely access to assessment, treatment planning, counseling services, medication management, crisis stabilization, and ongoing recovery supports. THRIVE Wellness and Recovery, Inc. also assists individuals in navigating complex behavioral health systems and connecting to community-based resources that support long-term stability and housing retention. Within these MOU's, SUD & MH providers clearly outline the services to be provided to CoC funded participants. These partnerships support coordinated referrals, warm handoffs, and service coordination, helping directly connect people experiencing homelessness with behavioral health and recovery services across the CoC, and b.) finally, by engaging SUD & MH partners, both CoC & non-CoC members, to present at membership meetings to explain services availability and discuss openings and admissions criteria.

1C-1b. Treatment and Recovery Services—Peer Support and Recovery Navigation.

Describe how your CoC partners with, or has projects that provide access to, peer recovery specialists or other forms of peer support and recovery navigation.

(limit 2,500 characters)

The CoC works with projects and community partners to connect individuals experiencing homelessness with substance use disorder (SUD) treatment, behavioral health services, recovery supports, and recovery navigation. The CoC engages CoC and non-CoC partners through quarterly Membership Meetings, where community providers share current information on treatment, recovery, and supportive services. Partners include Credo Community Center, which provides SUD services; the Mental Health Association of Jefferson County; and the Children's Home of Upstate New York, which provides Health Home and Medicaid care management. This information is communicated directly to program staff, who use these established referral pathways to connect participants with appropriate treatment and recovery resources.
The CoC also works with healthcare organizations, Managed Care Organizations (MCOs), and navigators to help participants access and remain connected to services. Community partners provide information on eligibility, enrollment, health literacy, and accessing available supports. In partnership with CDPHP, the CoC incorporated an HMIS intake question identifying CDPHP membership, allowing shelter and housing case managers to connect participants with CDPHP care managers. Care managers provide ongoing assistance with physical, mental, and behavioral healthcare, helping participants navigate services and maintain connections to treatment and supportive resources.
The CoC systematically shares updated information regarding behavioral health, SUD, recovery, and other community resources through Membership Meetings and email communications. When changes in referral or access processes require additional assistance, the Collaborative Applicant provides technical assistance and webinars. The CA also provides annual TA to new project applicants on coordinating with healthcare and behavioral health providers to connect participants to appropriate services.
The CoC promotes SSI/SSDI Outreach, Access, and Recovery (SOAR) training through Membership Meetings.
Through recovery-focused provider partnerships, established referral pathways, care management, and SOAR navigation, the CoC provides multiple avenues for participants to access SUD treatment, behavioral health services, recovery supports, and individualized recovery navigation.

1C-1c. Treatment and Recovery Services—Connecting Individuals Experiencing Serious Mental Illness with the Services Necessary to Promote Stability.

Describe how your CoC identifies individuals experiencing Serious Mental Illness and connects them with the services necessary to promote stability, such as Assertive Community Treatment teams and other models that combine intensive care coordination and assertive outreach with comprehensive treatment.

(limit 2,500 characters)

The Points North Housing Coalition (PNHC) Continuum of Care identifies individuals experiencing Serious Mental Illness (SMI) through coordinated access points including Coordinated Entry, street outreach, emergency shelters, hospitals, crisis response systems, behavioral health providers, the Jefferson County Assertive Community Treatment (ACT) Team, and community-based organizations. Through standardized assessment and engagement practices, Coordinated Entry helps identify individuals whose mental health needs contribute to homelessness, housing instability, frequent hospitalizations, or recurring crises and connects them to appropriate housing and supportive services. Individuals requiring intensive behavioral health interventions may be referred through the Single Point of Access (SPOA) process, which serves as a centralized pathway to specialized services, supportive housing, care coordination, and other community-based supports. For individuals with the highest service needs, the Jefferson County ACT Team provides multidisciplinary, community-based treatment through assertive outreach, psychiatric care, medication management, substance use treatment, crisis intervention, and housing support. Jefferson County also utilizes Assisted Outpatient Treatment (AOT) for eligible individuals whose history of treatment, noncompliance has contributed to repeated hospitalizations, incarceration, homelessness, or other adverse outcomes. Through a coordinated clinical and legal review process involving the Coordinator of Mental Health Services, treatment providers, Mental Hygiene Legal Services, the County Attorney's Office, and Supreme Court, AOT helps promote treatment engagement, stability, and access to necessary behavioral health services. By integrating housing providers, healthcare systems, behavioral health agencies, the Jefferson County ACT Team, AOT processes, and SPOA referrals, the PNHC CoC ensures that individuals with SMI are identified early and connected to the level of care and support necessary to achieve housing stability, reduce emergency service utilization and psychiatric hospitalization, improve treatment engagement, and support long-term recovery, independence, and community integration.

1C-1d. Treatment and Recovery Services—Coordination with Providers in Connection with Drug or Other Specialty Courts.

Identify at least one partnership the CoC has with a provider or entity providing services in connection with Drug Courts and other specialty courts serving individuals with mental and substance use disorders, Assisted Outpatient Treatment (AOT) programs, and inpatient civil commitment.

(limit 500 characters)

PNHC maintains partnerships through CoC Membership w/ local Drug Courts & Mental Health Courts, working with court coordinators, treatment providers, & probation to connect participants experiencing SUD/BH issues to services. The Jefferson County and Lewis County Adult Drug Treatment Courts provide court-supervised treatment. These partnerships support housing stability, treatment engagement, & successful community integration for individuals w/ mental health & substance use disorders.

Describe how your CoC coordinates with the provider or entity identified above to support housing stability and movement towards independence, including by leveraging court orders.

(limit 2,500 characters)

PNHC coordinates closely with Drug Courts, Mental Health Courts, Assisted Outpatient Treatment (AOT) programs, and behavioral health providers to support housing stability and long-term independence for individuals experiencing homelessness who have significant mental health or substance use disorders. Through regular communication, case conferencing, discharge planning, and participation in Coordinated Entry, these partners work together to identify housing needs and connect individuals to appropriate housing and supportive services. Court and treatment partners refer eligible individuals to Coordinated Entry and CoC-funded housing programs, ensuring that housing needs are addressed alongside treatment and recovery goals. CoC providers collaborate with court personnel, mental health professionals, and care coordinators to develop housing plans that support compliance with treatment requirements while promoting housing stability. This coordination helps reduce barriers to housing and supports successful community integration. For individuals subject to court-ordered treatment, including AOT orders, Drug Court participation requirements, or other specialty court mandates, housing providers coordinate with treatment teams to ensure participants can access behavioral health services, medication management, recovery supports, transportation assistance, and other services necessary to maintain housing. Court orders often provide a structured framework for engagement, allowing providers to leverage mandated participation in treatment and service planning to improve housing outcomes. The CoC's collaborative approach promotes continuity of care during transitions from inpatient facilities, treatment programs, correctional settings, and court supervision into permanent housing. By aligning housing resources with behavioral health and recovery services, PNHC helps individuals achieve greater housing stability, increase self-sufficiency, reduce returns to homelessness, and progress toward long-term independence in the community.

1C-1e. Treatment and Recovery Services—Partnership with Local Crisis System of Care.

Identify at least one partnership the CoC has with the local crisis system of care including 988 and crisis contact centers, mobile crisis and outreach services, and crisis stabilization services.

(limit 500 characters)

The CoC partners with the regional 988 Suicide & Crisis Lifeline center & mobile crisis outreach providers to connect individuals experiencing crisis with immediate behavioral health support. In PNHC, the Children’s Home of Jefferson County and Citizen Advocate provides MH outreach services, crisis intervention, referrals, & connections to services. Service providers can make referrals to them for crisis assessment, intervention, stabilization, & ongoing housing-focused services.

1C-1f.	Treatment and Recovery Services—Availability of Units for Persons Reporting Chronic Substance Use.	
	You must upload the List of CoC Program Projects and the Number of Units that require Substance Abuse Treatment attachment to the 4A. Attachments Screen.	

Identify the number of CoC Program-funded units that require program participant engagement in substance abuse treatment services as a condition of continued participation in the program in accordance with 24 CFR 578.75.	14

1C-1g.	Treatment and Recovery Services—24/7 Access to Detox, Residential, or Inpatient Treatment.	

Is there 24/7 access to detox, residential, and inpatient behavioral health treatment within the geographic area of your CoC?	Yes

1C-1h. Treatment and Recovery Services—Formal Partnership with Behavioral and Mental Health Facilities.

Identify at least one formal partnership the CoC has with a Certified Community Behavioral Health Clinic (CCBHC), Community Mental Health Center (CMHC), SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider, Grants for the Benefit of Homeless Individuals (GBHI) provider, or a similar facility if none of the above are located in the geographic area.

(limit 500 characters)

NY-522 maintains formal partnerships with behavioral health and recovery service providers throughout the CoC. One example is the formal partnership with THRIVE Wellness and Recovery, Inc., a Certified Community Behavioral Health Clinic (CCBHC), which provides coordinated access to mental health treatment, substance use disorder services, crisis intervention, peer support, and care coordination for individuals experiencing homelessness.

1C-1i. Treatment and Recovery Services—Sober Housing Availability.

Identify at least one new or existing CoC Program-funded project that operates sober housing in accordance with 24 CFR 578.93(b)(5).

(limit 500 characters)

The Points North Housing Coalition (PNHC) CoC has no CoC Program-funded projects that operate sober housing in accordance with 24 CFR 578.93(b)(5). To address this gap, the CoC conducted outreach to behavioral health, substance use disorder, recovery housing, and other housing providers to identify potential partners. While no organization was prepared to establish a CoC-funded sober housing project this cycle, recovery housing remains a priority and outreach efforts will continue.

1C-1j. Treatment and Recovery Services—Warm Hand-Offs to Stable Housing Providers.

Describe how your CoC coordinates with the programs named in questions 1C-1a through 1C-1i to facilitate warm hand-offs to stable housing providers and prevent entry into homelessness.

(limit 2,500 characters)

The Points North Housing Coalition (PNHC) coordinates w/ behavioral health, court, crisis, & outreach programs to make warm handoffs to housing providers & prevent homelessness.
For outpatient mental health & substance use disorder care (1C-1a), PNHC collaborates w/ THRIVE Wellness and Recovery, Inc. to connect people experiencing homelessness or housing instability w/ counseling, substance use treatment, referrals, & behavioral health services. Partners coordinate referrals & follow-up so participants access care alongside housing assistance.
For peer recovery support (1C-1b), PNHC works w/ the Mental Health Association of Jefferson County to connect participants to peer supports that promote treatment engagement, service navigation, & sustained recovery while seeking or maintaining housing. Partners coordinate referrals & follow-up.
For serious mental illness services (1C-1c), PNHC coordinates w/ the Jefferson County Assertive Community Treatment (ACT) Team. Its intensive, community-based approach helps individuals with serious mental illness access treatment, case management, and supportive services while maintaining housing stability. Staff can link participants to housing providers while coordinating care & support.

For drug courts (1C-1d), PNHC works w/ the Jefferson County and Lewis County Adult Drug Treatment Courts to provide court-supervised treatment. Court & service partners identify housing needs, refer participants to housing resources, & coordinate treatment & housing plans that support stability & community integration.

For local crisis services (1C-1e), PNHC partners w/ the regional 988 Suicide & Crisis Lifeline center & mobile crisis outreach providers. Children's Home of Jefferson County and Citizens Advocates provide crisis outreach, intervention, stabilization, & referrals to social & community services. Crisis teams & housing providers coordinate immediate referrals & follow-up when a person's housing is at risk.

1C-2.	Supportive Services Investment.	

Number

1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	$2,217,253
2. Of projects your CoC proposed to be funded in the FY 2026 CoC Program Competition, enter the total amount of funding for the supportive services budget line items.	$624,359
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	28%
4. Enter the amount of funding, leverage, match, and funding commitment from other formal partnerships in supportive services for the projects included in your CoC's FY 2026 ARD.	$243,704
5. Percent of your CoC's FY 2026 ARD (from element 1 above) that is the supportive services funding in proposed projects (from element 2 above) plus the amount of funding, leverage, match, and funding commitment from other formal partnerships in supportive services (from element 4 above).	39%

1C-3.	Participation Requirements for Supportive Services.
	You must upload the Language from Project Supportive Service Agreements attachment to the 4A. Attachments Screen.

What percent of your housing projects (TH, PH-PSH, PH-RRH, and Joint projects) require program participants to take part in supportive services (e.g. case management, employment training, substance use disorder treatment) in line with 24 CFR 578.75(h)?	100.00%

1C-4. Consulting with ESG Recipients.

Describe how your CoC has and will continue to consult with ESG recipients in the planning and allocation of ESG funds.

(limit 2,500 characters)

The Points North Housing Coalition (PNHC) regularly consults with the New York State Office of Temporary and Disability Assistance (OTDA), the Emergency Solutions Grant (ESG) recipient for the CoC geographic area, regarding the planning and allocation of ESG funds. Consultation occurs through ongoing CoC planning efforts, implementation of the Coordinated Entry System, and the development and review of the CoC's Written Standards. The Written Standards were developed in conjunction with ESG recipients, the CoC Collaborative Applicant, and service providers to allow input on standards, performance measures, and implementation processes for ESG- and CoC-funded projects. The PNHC Written Standards establish requirements for ESG- and CoC-funded projects and provide guidance for homelessness prevention, street outreach, emergency shelter, rapid re-housing, HMIS, and coordinated access to services. All projects receiving ESG or CoC funding are required to comply with these standards. PNHC's Coordinated Entry System is used to assess household needs and facilitate referrals to appropriate housing and service interventions. The Written Standards require ESG- and CoC-funded projects to participate in Coordinated Entry and operate in accordance with the CoC's Coordinated Entry Policies and Procedures. PNHC will continue to consult with OTDA through Coordinated Entry implementation, Written Standards review, and broader CoC planning efforts to ensure ESG-funded activities remain aligned with CoC policies and community needs throughout Jefferson, Lewis, and St. Lawrence Counties.

1C-4a. Coordination with Emergency Shelter Providers.

Describe how your CoC coordinates with shelter providers to connect individuals and families with CoC assistance.

(limit 2,500 characters)

The CoC coordinates with shelter providers to connect individuals and families with CoC assistance through Coordinated Entry (CE). Emergency shelter providers, such as Lewis County Opportunities and the Victims Assistance Center of Jefferson County, serve as key access points to the CoC's coordinated entry system. Local Departments of Social Services (DSS), which coordinate emergency hotel and motel placements and operate code blue shelters and warming centers, are additional partners and access points in the CE system. Shelter providers and DSS work with individuals and families experiencing homelessness to connect them to CE, complete required assessments and documentation, and ensure their information is entered and maintained in HMIS. Individuals and families are then prioritized according to the CoC's established CE policies and referred to available CoC-funded housing programs, including transitional housing, rapid rehousing, permanent supportive housing, and joint TH-RRH projects.
Shelter providers also participate in CE Case Conferencing, where they communicate with CE staff regarding participants who may be eligible for available CoC housing opportunities, provide updates regarding participants' housing needs and circumstances, and coordinate referrals and next steps. This ongoing communication helps the CoC identify appropriate housing resources and facilitate connections between shelter residents and available CoC assistance.
Shelter providers and their agencies also participate in CoC governance and CE planning through CoC Membership, CoC Board, and the CE Advisory Committee. Representatives from Lewis County DSS and Jefferson County DSS serve on the CoC Board and Membership. Representatives from the Victims Assistance Center of Jefferson County, St. Lawrence County DSS, and Lewis County Opportunities participate in Membership. This participation gives shelter providers opportunities to inform CE policies and processes, identify barriers to connecting shelter residents with housing assistance, and collaborate with the CoC on improvements to the homelessness response system.

1C-5. Data Sharing to Inform the Homelessness Response System.

Describe how your CoC has or will share PIT, HIC, HMIS, and System Performance data with state and local government as permitted by law in order to inform the homelessness response system.

(limit 2,500 characters)

The CoC uses its Homeless Management Information System (HMIS) to collect, analyze, and report information about homelessness, including characteristics of individuals and households experiencing homelessness, services provided, housing outcomes, and system performance. HMIS data support required reporting, including the Point-in-Time (PIT) Count, Housing Inventory Chart (HIC), System Performance Measures (SPMs), demographic reports, and other system-level reports used for planning, performance evaluation, and resource allocation.
The CoC shares PIT, HIC, HMIS, and System Performance data with state and local government, as appropriate and permitted by law, through required reporting, aggregate reports, data analysis, and established data-sharing processes. Information is shared in accordance with HMIS policies and procedures, privacy requirements, federal and state laws, and applicable client consent and data-release protocols.
The CCHMIS Privacy Notice establishes permitted uses and disclosures of HMIS personally identifying information (PII), including disclosures required by law and the creation of de-identified reporting. Other uses or disclosures of HMIS PII require prior written participant consent unless otherwise permitted under the Privacy Notice and applicable law. Published CCHMIS reports contain aggregate data and do not include participant-level or identifying information.
CARES of NY, Inc., as the CCHMIS System Administrator, maintains security and confidentiality protections, including controlled system access, privacy and security training, confidentiality agreements, annual monitoring, and secure transmission of HMIS data.
The CoCs also report required HMIS data to NYSHADE, the statewide homeless data system administered by the New York State Office of Temporary and Disability Assistance (OTDA). NYSHADE receives specified HMIS data for statewide analysis, planning, policy development, and resource allocation. The NYSHADE process uses de-identification to remove identifying information, with OTDA access limited to de-identified aggregate information.
The resulting data are used to identify system needs, evaluate outcomes, inform resource allocation, and strengthen coordination among government and community partners in the homelessness response system.

1C-5a. Using Other Data Sources Alongside HMIS to Improve Care.

Describe how your CoC utilizes other data sources alongside HMIS to improve care (e.g., health care utilization and claims data, electronic health care record data; admission, discharge, and transfer data; and law enforcement and corrections system data).

(limit 2,500 characters)

To elevate the quality of care, optimize system performance, and drive measurable improvements in housing stability for individuals and families experiencing homelessness, the Points North Housing Coalition (PNHC) Continuum of Care (CoC) will implement a strategic integration of our Homeless Management Information System (HMIS) with external, cross-system datasets. This initiative will establish a robust multi-sector analytics framework designed to identify, prioritize, and serve high-utilization populations.

A cornerstone of this initiative is the strategic use of New York State Department of Health (NYSDOH) resources. Through this collaboration, the PNHC CoC will leverage the Statewide Planning and Research Cooperative System (SPARCS) to evaluate critical socio-demographic and public health trends. By synthesizing these population-level data sources with our existing HMIS infrastructure, the CoC will gain the capacity to track and quantify correlations between regional health disparities and housing instability across our service area.

Our methodology will specifically target the SPARCS Inpatient Discharges dataset for advanced data modeling. By isolating records with government-assisted payment types—specifically Medicare and Medicaid—and analyzing intersecting variables such as clinical diagnosis and patient disposition, our analytics framework will map distinct cohorts and geographic areas at the highest risk of homelessness.

To ensure a comprehensive view of regional vulnerability, the PNHC CoC will additionally integrate the NYS Division of Criminal Justice Services Crime Index. Conducting a correlation analysis between regional crime index data and aggregate counts of individuals utilizing emergency shelters or street outreach projects across Jefferson, Lewis, and St. Lawrence counties will allow us to prioritize support services in these areas and help lower these indices.

By layering HMIS utilization metrics with SPARCS inpatient discharges and regional crime data, this data modeling initiative will empower the PNHC CoC to deploy targeted, data-driven interventions exactly where they are most needed. Ultimately, this framework ensures that community resources are efficiently allocated to the most highly vulnerable populations, advancing long-term housing stability across Points North.

1C-6. Employment and Workforce Development Partnership.

Identify at least one partnership the CoC has with employment and workforce development programs and organizations such as the Local Workforce Development Board, State Workforce Agency, American Job Center (also known as One-Stop Career Centers), registered apprenticeship program, community and technical college, union training program, adult education provider, or State Vocational Rehabilitation agency.

(limit 2,500 characters)

The PNHC CoC partners with Jefferson-Lewis Workforce Development through an MOU with Jefferson County DSS (JCDSS). The local One-Stop system, known as The WorkPlace, connects clients in permanent housing (PH) and transitional housing (TH) programs with employment and workforce development services. Participants in Jefferson County can access these services throughout their program participation, supporting continued employment progress, increased earned income, and long-term housing stability.

1C-7. Street Outreach–Cooperation with First Responders and Law Enforcement.

Describe in the field below how your CoC's street outreach projects (including co-response) cooperate with first responders and law enforcement to increase positive interactions in order to increase housing and service engagement and promote use of CoC services.

(limit 2,500 characters)

The CoC promotes positive interactions between people experiencing homelessness, law enforcement, first responders, and street outreach teams through coordinated outreach efforts tailored to the challenges of serving rural communities. Law enforcement is represented on the CoC Board, supporting ongoing collaboration on homelessness response strategies. Street outreach providers coordinate with the New York State Police, Samaritan Medical Center, Roswell P. Flowers Memorial Library, and other community partners to identify and engage individuals experiencing unsheltered homelessness and connect them to housing and supportive services. In addition, county Departments of Social Services operate 24/7 call lines that are promoted to community partners, businesses, hospitals, and the public to facilitate referrals for individuals experiencing homelessness and in need of assistance. The CoC also collaborates with specialized outreach programs serving veterans, including VA Outreach, Health Care for Homeless Veterans (HCHV), and Soldier On, which engage unsheltered veterans and connect them to housing, healthcare, and supportive services. The CoC further partners with County Mental Health Departments and Assertive Community Treatment (ACT) teams to engage individuals experiencing serious mental illness and connect them to appropriate care and supports. Through referral coordination, resource sharing, stakeholder engagement, and ongoing collaboration among law enforcement, behavioral health providers, veteran service organizations, healthcare partners, and street outreach teams, the CoC increases housing and service engagement while promoting housing-focused responses to homelessness.

1C-8. Family or Support Network Reunification.

Describe how your CoC, or your recipients, assist with family or support-network reunification efforts for individuals experiencing homelessness or living in CoC Program-funded housing (e.g., case management, travel costs, arrangement of assistance in another geographic area).

(limit 2,500 characters)

The CoC recognizes that reconnecting individuals and families with safe and appropriate family members or support networks can be an effective strategy for resolving homelessness and promoting long-term housing stability. The CoC prioritizes family reunification and preservation when safe and appropriate. Providers recognize that strengthening family connections is a key strategy for preventing and ending homelessness and incorporating family engagement, counseling, and mediation to support housing stability and family preservation. Providers routinely coordinate with the Department of Social Services (DSS), social service agencies, veterans' programs, youth-serving organizations, behavioral health providers, and housing programs in other jurisdictions to ensure participants are connected to appropriate services and supports before relocation occurs. When appropriate, DSS's in Jefferson, Lewis, and St. Lawerence Counties assist with referrals, benefits, transportation resources, and connections to services in another geographic area. Prior to reunification, staff verify that the housing arrangement and support system are stable, appropriate, and likely to support the participant's long-term housing goals. For households residing in CoC Program-funded housing, case managers continue to evaluate opportunities to strengthen natural support networks as part of ongoing housing stability planning. Participants are encouraged to build and maintain positive connections with family members and community supports when doing so aligns with their goals and promotes self-sufficiency. These relationships can serve as important resources for crisis prevention, social integration, and long-term housing retention. Through coordinated case management, collaboration with DSS and other community partners, transportation assistance, and individualized service planning, the CoC and its recipients support safe and appropriate family and support-network reunification efforts as one of several strategies for helping individuals and families exit homelessness and achieve lasting housing stability.

1C-9	**Partnering with Public Housing Agencies—Agreement to Enable Transition to HUD Assisted Housing.**		
	Does your CoC have an agreement with at least one public housing agency to enable participants to transition from Transitional Housing, Rapid Re-Housing, and Permanent Supportive Housing to HUD assisted housing?	Yes	

1C-10. Protecting Public Safety—Cooperation with Law Enforcement.

You must upload the Evidence of Coordination and Non-Interference with Local Efforts to Advance Protecting Public Safety attachment to the 4A. Attachments Screen.

Describe how your CoC cooperates and does not interfere with or impede local efforts to advance the objectives below, and assists first responders in providing services to homeless individuals.

(limit 2,500 characters)

The NY-522 Points North Housing Coalition (PNHC), serving Jefferson, Lewis, and St. Lawrence Counties, cooperates with local governments, law enforcement, probation, first responders, outreach, behavioral health and SUD providers, healthcare organizations, and partners to support public safety while connecting people experiencing homelessness to housing and services. PNHC does not interfere with or impede lawful local efforts related to encampments, public safety, substance use, or other community concerns.
PNHC's governance structure supports coordination among homeless service providers, local government, public safety, behavioral health/recovery providers, and partners. The PNHC Board includes county Departments of Social Services, county government, probation, housing and homeless service organizations, and behavioral health/recovery services. Coordinated Entry and committees provide opportunities to coordinate responses and referrals.
Outreach providers work with local partners when people experiencing homelessness are encountered in public spaces or during public safety responses. Providers assist first responders by identifying shelter, housing, behavioral health, SUD treatment, healthcare, and other resources and connecting them.
PNHC supports local efforts to address tents and encampments on public property by coordinating outreach and connecting individuals to shelter, housing, and services. When local authorities act in public spaces or encampments, providers coordinate outreach and referrals and do not obstruct lawful enforcement or public safety activities.
The CoC supports responses to public substance use, behavioral health crises, and danger to self or others. Through Coordinated Entry, case conferencing, and referral networks, providers coordinate with behavioral health, SUD, emergency, and public safety systems to facilitate services consistent with applicable laws and local protocols.
PNHC shares information, including location information, with authorized partners consistent with SORNA and applicable privacy and confidentiality requirements. Through its governance and partnerships, PNHC maintains communication among homeless service providers, local governments, public safety agencies, and first responders.
Through these partnerships, PNHC supports public safety, assists first responders, and facilitates access to outreach, shelter, housing, SUD treatment, behavioral health, healthcare, and services.

1C-10a. Protecting Public Safety—Plan to Quickly Clear Tents and Encampments.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to quickly clear tents and encampments on public property and connect individuals who are camping in public with appropriate services and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

While Points North does not have a specific countywide preventive encampment ordinance, the Counties utilize homelessness prevention programs, emergency housing placements, coordinated outreach, behavioral health services, and affordable housing initiatives to reduce the conditions that lead to encampments. Due to the rural geographic area, large-scale public encampments are not common, and 13 unsheltered homeless individuals were identified in the 2026 PIT Count. To leverage beneficial policies, the Points North CoC will continue implementing a coordinated, housing-focused response to unsheltered homelessness. The CoC will partner with local departments of social services, county mental health agencies, healthcare providers, law enforcement agencies, tribal and community organizations where applicable, and homeless service providers to conduct proactive outreach, assess needs, and connect unsheltered individuals to services before any encampment closure occurs. Multidisciplinary outreach teams will prioritize enrollment in Coordinated Entry, behavioral health treatment, substance use services, healthcare, benefits assistance, veteran services, and housing navigation. The CoC will prioritize unsheltered households for available CoC housing, and other housing opportunities while continuing to strengthen partnerships with landlords and housing providers. The CoC will also leverage regional coordination to address transportation barriers and ensure individuals in remote areas can access shelter, healthcare, and housing resources. Through coordinated outreach, advance notice of closures, person-centered case management, and collaboration across housing, healthcare, behavioral health, and public systems, the CoC will maximize opportunities to transition individuals from encampments into safe shelter, supportive services, and permanent housing.

1C-10b. Protecting Public Safety—Current Status of Tents and Encampments.

Describe the current status of tents and encampments in the CoC's geographic area.

(limit 2,500 characters)

The Points North Housing Coalition (PNHC) Continuum of Care, serving Jefferson, Lewis, and St. Lawrence Counties, experiences a relatively low level of unsheltered homelessness, with 13 individuals identified as unsheltered during the most recent Point-in-Time Count. Unsheltered individuals are typically found in tents, vehicles, wooded areas, abandoned structures, or other locations not intended for human habitation. Given the rural nature and large geographic area of the North Country, unsheltered homelessness is generally dispersed rather than concentrated in large, established encampments. The PNHC utilizes a coordinated, housing-focused approach through Coordinated Entry, street outreach, emergency shelters, Departments of Social Services, and community-based organizations. Outreach teams regularly monitor outdoor locations and respond to reports of tents, encampments, and youth sleeping in public spaces. As a result of these ongoing efforts, large encampments are uncommon, and individuals are often connected to shelter, housing resources, healthcare, behavioral health services, and other supports before encampments become established. In areas that include state forests and other public lands, camping is regulated by the New York State Department of Environmental Conservation (DEC), which limits camping in certain locations, requires permits for extended stays or larger groups, and prohibits many forms of long-term or unauthorized encampment activity. When tents or encampments are identified, the CoC prioritizes outreach, engagement, diversion, shelter access, and permanent housing placement whenever possible. Community partners work collaboratively to assess needs, address barriers to housing, and connect individuals to supportive housing, behavioral health treatment, substance use services, mainstream benefits, and other resources. Through continued collaboration among local governments, outreach providers, housing agencies, healthcare organizations, emergency shelters, and behavioral health partners, the PNHC works to quickly identify unsheltered individuals, prevent the development of larger encampments, reduce the duration of homelessness, and promote long-term housing stability and well-being throughout Jefferson, Lewis, and St. Lawrence Counties.

1C-10c. Protecting Public Safety—Plan to Decrease the Public Use of Illicit Drugs.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to decrease the public use of illicit drugs and quickly connect individuals who are using illicit drug in public with appropriate services and/or law enforcement and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

In the PNHC, public drug use is addressed through coordinated outreach, overdose response, treatment engagement, and public safety partnerships. New York State law prohibits appearing in a public place under the influence of narcotics or another drug when the person may endanger themselves or others. NY-522 leverages this policy by coordinating with law enforcement when public drug use creates an immediate safety concern while also connecting individuals with appropriate treatment and supportive services. Outreach teams conduct outreach throughout the geographic area and work with individuals experiencing homelessness and substance use disorders to provide referrals and connections to appropriate services. The Points North Housing Coalition includes substance use, mental health, social service, housing, probation, and community-based organizations, including Thrive Wellness and Recovery, county Departments of Social Services, Probation, Soldier On, and other local providers, strengthening coordination between housing and behavioral health services. The CoC works with law enforcement, healthcare providers, substance use and mental health providers, and other community partners to provide referrals, education, treatment, recovery support, and connections to housing and other services. These policies have coincided with a decline in overdose deaths. These efforts have coincided with a decline in reported overdose deaths. According to CDC provisional data, during the 12-month period ending December 2025, there were 31 reported deaths across the CoC; During the 12-month period ending December 2024, the three counties reported 38 overdose deaths. NY-522 will continue leveraging these partnerships and outreach practices to decrease public use of illicit drugs and quickly connect individuals with substance use treatment, mental health services, housing, and recovery supports. The CoC will continue strengthening coordination between outreach providers, law enforcement, behavioral health providers, and community organizations while utilizing service-based responses when appropriate and coordinating with law enforcement when there are immediate public safety concerns.

1C-10d. Protecting Public Safety—Current Status of Overdoses and Illicit Drug Use in Public Spaces.

Describe the current status of overdoses and illicit drug use in public spaces in the CoC's geographic area.

(limit 2,500 characters)

According to the CDC, the status of overdose deaths reported during December 2024 to December 2025 showed that NY-522's three counties reported 31 overdose deaths, including Jefferson 18 and St. Lawrence 13. Due to the rural geographic area, it is not common for there to be large gatherings of individuals using illicit drugs in public. The CoC will continue to partner with outreach teams, law-enforcement, local government, and recovery services to ensure the decrease in amount of overdoses and illicit drug use in public spaces.

1C-10e. Protecting Public Safety—Standards to Address Danger to Self or Others.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to utilize standards that address homeless individuals who are a danger to themselves or others (e.g., involuntary commitment) and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

Points North uses New York Mental Hygiene Law standards and its crisis-response system when a homeless individual may be a danger to self or others. Under NY Mental Hygiene Law §9.41, authorized police/peace officers may take a person into custody and direct removal to an authorized hospital or Comprehensive Psychiatric Emergency Program when the person appears mentally ill and is behaving in a manner likely to result in serious harm to self or others (Involuntary Commitment). The law allows for emergency mental health evaluations when a person presents a substantial risk of harm to themselves or others or is unable to meet essential needs such as food, shelter, personal safety, or medical care due to mental illness. The CoC can work closely with the Jefferson County Community Services Department, St. Lawrence County Community Services, and the Lewis County Community Services Department to coordinate behavioral health assessments, crisis intervention, treatment referrals, supportive housing placements, and ongoing recovery services. Through these partnerships, individuals experiencing homelessness and behavioral health challenges can be connected to care more quickly and effectively. The CoC can also coordinate with local hospitals and behavioral health providers, including Samaritan Medical Center in Watertown, Claxton-Hepburn Medical Center in Ogdensburg, Canton-Potsdam Hospital, and Claxton-Hepburn Community Services, to support emergency psychiatric evaluations, crisis stabilization, discharge planning, and connections to community-based treatment. When outreach teams encounter individuals, whose mental illness prevents them from safely meeting basic needs or maintaining housing, Article 9 provides a pathway for assessment and intervention. By connecting behavioral health, housing & supportive service partners, outreach staff support timely intervention, public safety, long-term stability, housing access & continued behavioral health support.

1C-10f. Protecting Public Safety—Share Information in Accordance with SORNA.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to comprehensively share information, including location information, in accordance with the Sex Offender Registry and Notification Act (SORNA) and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

The CoC has an established practice for sharing information related to Sex Offender Registry (SOR) status. During Coordinated Entry (CE) assessments, individuals are asked to disclose SOR status and potential barriers to housing and services. This information is documented, and staff coordinate with local law enforcement when an individual with SOR status reports relocating and location notification is appropriate. Staff use legally available public registry information for safety planning, housing, supervision, and services. Partners are informed of SOR status when legally appropriate, and referrals are made only to programs able to serve individuals with SOR status.
The CoC's confidentiality, consent, and authorized-disclosure requirements help ensure lawful information sharing, while privacy restrictions can limit disclosure of personally identifying and location information. The CoC mitigates these restrictions by obtaining consent when required, sharing only legally permitted information, using public registry information when authorized, and coordinating with law enforcement when notification or location information may legally be shared.
The CoC will leverage these practices by continuing to incorporate SOR and housing/service-barrier questions into CE assessments, training participating agencies, coordinating with law enforcement and service providers, and using outreach and CE to maintain contact when individuals relocate. These practices help providers identify appropriate housing and services while ensuring relevant partners have information needed for safety, supervision, and service coordination.
At the end of 2025, 43,064 individuals were registered sex offenders in New York State. This statewide quantitative data demonstrates the scale of the population potentially requiring housing and services. Qualitatively, the CoC's CE assessment process and provider coordination help identify barriers and connect individuals with appropriate housing and services while protecting confidentiality. The CoC will continue reviewing assessment information, referrals, case practices, and partner feedback to strengthen timely, lawful information sharing.

1C-11. Outreach Strategy.

Describe your CoC's strategy to outreach to all individuals and families experiencing homelessness across your geographic area.

(limit 2,500 characters)

The CoC utilizes a coordinated outreach strategy to identify, engage, and assist individuals and families experiencing homelessness throughout its geographic area, including people who are unsheltered and not otherwise connected to services. Recognizing the challenges associated with serving rural communities, the CoC collaborates with human service organizations, public libraries, healthcare providers, law enforcement agencies, and county mental health providers to identify individuals experiencing homelessness and connect them to available resources. The Department of Social Services in each county maintains a 24/7 call line that is promoted to businesses, hospitals, and other community partners to facilitate referrals when individuals experiencing unsheltered homelessness are identified. The CoC coordinates with specialized outreach programs serving veterans, including the VA Outreach Program, Soldier On, and Health Care for Homeless Veterans (HCHV). These programs identify and engage unsheltered veterans and connect them to housing, healthcare, and supportive services. The CoC also uses membership meetings to inform community stakeholders about available resources and outreach services, helping strengthen referral pathways throughout the region. The CoC maintains partnerships with county mental health departments that administer Assertive Community Treatment (ACT) programs. These multidisciplinary teams engage individuals experiencing serious mental illness who may not be connected to traditional service systems and help connect them to appropriate services and supports. Outreach efforts occur year-round and are supplemented by the annual Unsheltered Point-in-Time Count. Additional outreach activities are conducted for populations that may be less likely to seek assistance, including veterans and individuals experiencing serious mental illness or substance use disorders. All outreach providers utilize client-centered and trauma-informed approaches, including staff with lived experience, to build trust, reduce barriers to assistance, and connect individuals and families experiencing homelessness to housing and supportive services.

1C-12.	Collaboration Related to Children and Youth–Written Agreements with Early Childhood Services Providers.	

Select 'Yes' or 'No' in the chart below to indicate whether your CoC or HUD-funded projects in the CoC have written agreements with the listed providers of educational supports and services for children ages 0-5:

		Written Agreement
1.	Child Care (including Child Care and Development Fund)	No
2.	Early Childhood Providers	No
3.	Early Head Start	No
4.	Home Visiting Program (including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)	No
5.	Head Start	No
6.	Healthy Start	No
7.	Public Pre-K	No
8.	Tribal Home Visiting Program	No
	Other (limit 150 characters)	
9.		

1C-12a.	Collaboration Related to Children and Youth–Formal Partnerships with Schools and Youth Education Providers.	

Select 'Yes' or 'No' in the chart below to indicate the youth education providers your CoC has a formal partnership with:

1.	McKinney-Vento Liaison(s) (including State Education Agency (SEA) or Local Education Agency (LEA))	Yes
2.	School District(s)	Yes
3.	General Education Development (GED) Program(s)	No
4.	Community College(s)	No
5.	Technical College(s)	No
6.	Other Post-Secondary Education Provider(s)	No

1C-12b.Collaboration Related to Children and Youth—Informing Individuals and Families who Become Homeless about Eligibility for Educational Services.

Describe your CoC's written policies and procedures to inform individuals and families who become homeless of their eligibility for educational services.

(limit 2,500 characters)

The CoC has adopted policies & procedures w/in its Written Standards to ensure all programs consistently & accurately inform indvs. & families who have recently begun experiencing homelessness of available ed. services & related eligibility. This CoC policy requires CoC providers serving households w/children to designate a specialized staff person as the educational liaison to inform indvs. & families of eligibility for schooling & to provide direct support to set up services to ensure no disruption in current ed. services for students entering shelter or transitioning from shelter into permanent housing. Specifically, educational liaisons ensure children continue to be enrolled in school & connected to age-appropriate services in the community (Head Start, Public Pre-K, Individuals w/Disabilities Ed. Act Part C: Infant & Toddler Program, McKinney-Vento Ed. Services as well as county opportunities for High School Equivalency, job training, & higher education courses). Educational liaisons connect & work w/homeless indvs., families, schools, & education programs to ensure appropriate educational services are made available & barriers to services are removed. For example, CoC agency staff are required to coordinate w/McKinney-Vento Liaisons in families' existing school districts to coordinate transportation services & ongoing enrollment. Additionally, educational liaisons connect families w/CoC Member, Northern Regional Center for Independent Living, which actively advocates for families' rights w/in school districts when necessary. The Regional Advisory Board on Youth Homelessness regularly conducts a survey of all CoC funded agencies to collect contact information on identifying agency appointed staff serving as the educational liaison. Moving forward, the CoC program monitoring process will incorporate a review of agency connection w/the local schools & corresponding McKinney-Vento representatives & will follow protocols to ensure all children are appropriately served by their school. At the CoC system level, the CoC fosters strong partnerships w/education via the McKinney-Vento liaisons by encouraging liaison participation on the CoC Board & relevant committee work. The CoC meets annually w/McKinney-Vento liaisons to specifically review CoC policies & procedures to ensure full compliance & best practice w/regs. Lastly, the Department of Social Services links indvs. & families to accessible job training, & higher ed. courses w/in the county.

1C-12c. Collaboration Related to Children and Youth—Coordination with Foster Care or Child Welfare Services.

Describe how your CoC coordinates with foster care or child welfare services to assist youth transitioning from public systems of care.

(limit 2,500 characters)

The CoC works closely with child welfare agencies and housing providers across Jefferson, Lewis, and St. Lawrence Counties to support youth as they transition to independent adulthood. The Foster Youth to Independence (FYI) program provides HUD-funded Housing Choice Voucher assistance to eligible youth transitioning from foster care. County Departments of Social Services serve as critical referral partners, helping identify and connect eligible youth and families with available housing resources. Through these partnerships, youth may access Independent Living Services, housing navigation and case management support, and rental assistance opportunities. These services are coordinated among local DSS offices, housing authorities, and community-based organizations to promote housing stability and successful long-term outcomes. Through these partnerships, the CoC and child welfare system work together to identify emerging needs, coordinate system planning, strengthen referral pathways, and improve outcomes for youth who are at risk of homelessness as they exit foster care. These collaborative relationships create direct connections between child welfare and homeless response systems, ensuring youth receive housing-focused case management, coordinated service planning, and warm handoffs to community resources prior to discharge from care. Housing stability is strengthened through partnerships with local public housing authorities and organizations operating youth-focused housing programs. Through coordinated referrals, case conferencing, and ongoing collaboration, eligible youth are connected to rental assistance, housing navigation services, tenancy supports, employment resources, and other supportive services that help them successfully transition into and maintain permanent housing. As a result, youth exiting foster care are connected more quickly to permanent housing resources, experience fewer gaps between system discharge and housing placement, and receive ongoing support to maintain housing stability. By integrating child welfare partners into regional planning and leveraging targeted housing resources such as FUP and FYI vouchers, the CoC has developed a coordinated system that prioritizes prevention, rapid connection to housing, and sustained support for youth transitioning from foster care.

1C-12d. Collaboration Related to Children and Youth—Coordination with Runaway and Homeless Youth (RHY)-funded Providers.

Describe how your CoC coordinates with RHY-funded providers including Street Outreach Programs, Basic Center Programs, Transitional Living Programs, and Maternity Group Homes where such providers exist.

(limit 2,500 characters)

The CoC does not directly receive RHY funding; however, it maintains strong partnerships with youth-serving providers that deliver emergency shelter, transitional housing, street outreach, counseling, and supportive services to runaway and homeless youth. Through coordinated entry, referrals, and collaborative case planning, the CoC works to ensure youth experiencing homelessness are connected to appropriate resources and housing opportunities throughout the region.

1C-13. Collaboration Related to Families with Children—TH or RRH Project Dedicated to Serving Families with Children.

Identify at least one Rapid Rehousing (RRH) or Transitional Housing (TH) project in the CoC that primarily or exclusively serves families with children experiencing homelessness in accordance with 24 CFR 578.93(b).

(limit 500 characters)

PNHC has one Transitional Housing project that primarily serves families with children experiencing homelessness: Jefferson County DSS DV TH. The project provides safe temporary housing, case management, housing stabilization services, and supportive services for families experiencing homelessness, including survivors of domestic violence. It works with local service providers and community partners to promote safety, housing stability, and long-term self-sufficiency.

1C-13a. Collaboration Related to Families with Children—Supportive Services to Improve Income to Pay Rent.

Describe how the project(s) identified in 1C-13 provides supportive services focused on improving incomes to pay rent, such as workforce development, job training, or registered apprenticeship programs.

(limit 2,500 characters)

PNHC has one Transitional Housing project that primarily serves families with children experiencing homelessness: Jefferson County DSS DV TH. The project provides safe temporary housing, case management, housing stabilization services, safety planning, and comprehensive supportive services designed to increase family income, promote self-sufficiency, and support long-term housing stability for families experiencing homelessness, including survivors of DV. Through individualized case management, program staff work with participants to assess employment, education, financial, and safety needs and develop service plans that include income growth and housing goals. The project offers employment-focused services such as job readiness preparation, resume development, interview coaching, referrals to workforce development programs, educational/vocational opportunities. Participants receive assistance identifying and addressing barriers to employment, including transportation challenges, childcare needs, the impacts of domestic violence, and gaps in education or work history. Families are also connected to mainstream benefits and community resources that help stabilize household finances while employment goals are pursued. In addition, the project provides financial literacy education, budgeting assistance, money management support, and housing stabilization services to help participants prepare for and maintain permanent housing. Staff help families develop realistic plans for increasing earned income, managing household expenses, and assuming long-term rental obligations. Progress toward employment & income goals is regularly reviewed and service plans are adjusted as needed to support successful outcomes. Jefferson County DSS DV TH collaborates with local service providers, DV service organizations, workforce development agencies, schools, and community partners to connect families with employment, training, educational, and supportive services. These partnerships help participants access opportunities that contribute to increased income, safety, and housing stability. Partnerships are formalized through written agreements and are updated as needed to ensure coordinated service delivery and continued access to resources for participating families. Through these combined efforts, the project helps families increase their income, improve financial stability, enhance safety, and build the resources necessary to successfully pay rent and maintain permanent housing.

1C-13b. Collaboration Related to Families with Children—Leveraging Funding from Mainstream Family Service Systems.

Describe how the project(s) identified in 1C-13 leverages funding from mainstream family service systems, such as Temporary Assistance for Needy Families (TANF).

(limit 2,500 characters)

PNHC has one Transitional Housing project that primarily serves families with children experiencing homelessness: Jefferson County DSS DV TH, a domestic violence-focused program serving survivors of domestic violence and their families. The project leverages funding and resources from mainstream family service systems, including Temporary Assistance for Needy Families (TANF), SNAP, Medicaid, childcare assistance, rental and utility assistance, and other supports available through local Departments of Social Services (DSS). Through individualized case management, staff assist families with benefit applications, eligibility reviews, documentation collection, and enrollment in programs that increase household income and financial stability. The project partners with local DSS offices, schools, healthcare providers, SOAR providers, workforce development agencies, domestic violence service providers, and community organizations to connect families to cash and non-cash benefits, SSI/SSDI, educational opportunities, childcare resources, and other supports that promote housing stability, safety, and long-term self-sufficiency. The CoC's strategy for increasing non-employment cash income focuses on building strong relationships with community stakeholders and educating homeless service providers on available benefits, qualifying factors, and referral processes. DSS representatives regularly engage with the CoC to provide updates on benefit programs and resources, helping providers better support families in accessing income and public assistance. The CoC also collaborates with SOAR providers to improve access to SSI/SSDI benefits for eligible adults and children. In addition, families are connected to food pantries, prepared meals, clothing resources, healthcare services, and other community supports that reduce household expenses and allow more income to be directed toward housing costs. These partnerships are formalized through written MOUs or collaborative agreements and are updated as needed to ensure coordinated service delivery. Through these efforts, Jefferson County DSS DV TH helps families maximize available resources, increase financial stability, enhance safety, and maintain permanent housing over the long term.

1C-13c. Collaboration Related to Families with Children—Combining Housing Assistance with Parental Support.

Describe how the project(s) identified in 1C-13 combines housing assistance with childcare, parenting support, pregnancy-related and child healthcare, and education.

(limit 2,500 characters)

PNHC has one Transitional Housing project that primarily serves families with children experiencing homelessness: Jefferson County DSS DV TH. The project combines safe temporary housing, case management, housing stabilization services, and supportive services with family-centered resources that promote housing stability, child well-being, safety, and long-term self-sufficiency for families experiencing homelessness, including survivors of domestic violence. Through individualized service planning, families are connected to childcare resources, parenting education and support programs, early childhood services, school-based supports, and community programs that strengthen family stability. The project also connects families to pediatric healthcare, Medicaid, behavioral health services, developmental screenings, immunizations, and other healthcare resources that support healthy child development. Children and youth are connected to local schools, early learning programs, tutoring services, transportation resources, and educational supports, while parents are linked to adult education, financial literacy, workforce development, and employment resources. Staff also help families access mainstream benefits and community resources that reduce household expenses and support housing retention. Jefferson County DSS DV TH partners with local schools, childcare providers, healthcare organizations, Departments of Social Services, early childhood service providers, domestic violence service organizations, workforce development agencies, service providers, and community organizations to provide coordinated services for families. These partnerships help ensure families have access to childcare, parenting support, healthcare, educational services, safety planning, and other resources that contribute to housing stability and positive outcomes for children. Partnerships are formalized through written MOUs, collaborative agreements, and referral networks and are updated as needed to ensure coordinated service delivery. Through these combined efforts, the project helps families achieve safe, stable housing while supporting the health, education, safety, and well-being of both parents and children.

1C-14. Collaboration with Veteran Serving Organizations—Partnership with the U.S. Department of Veterans Affairs or Veteran Serving Organization.

Identify at least one partnership the CoC has with the Department of Veterans Affairs or other Veteran Serving Organizations.

(limit 500 characters)

The CoC’s membership includes representatives from the U.S. Department of Veterans Affairs (VA), Soldier On, and Eagle Star Housing (joining spring 2027). The CoC partners with the VA through HUD-VASH and Supportive Services for Veteran Families (SSVF) to connect veterans experiencing homelessness with housing and supportive services. Partners coordinate through Coordinated Entry to facilitate referrals, identify housing needs, and connect veterans to housing, healthcare, and other resources.

1C-14a	Collaboration with Veteran Serving Organizations.	
	Select ‘Yes’ or ‘No’ in the chart below to indicate whether the partnership(s) identified in 1C-14 does the following:	

1.	Refers veterans identified by the CoC to VA or other Veteran Serving Organizations for assistance?	Yes
2.	Coordinates the provision of emergency shelter, supportive services, and housing for veterans?	Yes
3.	Ensures access to a full spectrum of employment and career pathway opportunities?	Yes
4.	Shares data with the Department of Veterans Affairs as appropriate?	Yes
5.	Identifies service gaps for veterans?	Yes
6.	Fills service gaps for veterans?	Yes

1C-15. Collaboration with Organizations who Address the Needs of Survivors of Domestic Violence, Dating Violence, Sexual Assault, and Stalking.

Identify at least one partnership your CoC has with victim service providers, state domestic violence coalitions, state sexual assault coalitions, anti-trafficking service providers or other organizations who help provide shelter, housing, and services to individuals and families of persons experiencing trauma or a lack of safety related to fleeing or attempting to flee domestic violence, dating violence, sexual assault, and stalking.

(limit 500 characters)

The CoC has partnerships with NYS DV coalitions & VSP's. The Victims Assistance Center (VAC), which is a VSP and part of the NYS DV and Sexual Assault Coalitions, & Thrive, the DV CE Lead actively participate on the Operations Committee and the Board and have been involved in the process of reviewing and approving the CoC Governance Charter and Written Standards. VAC works closely with Thrive, the DV CE Lead, that serves survivors of DV and is active in developing CE processes within the CoC.

1C-16. Collaboration with Justice System Re-entry Partners.

Identify at least one partnership your CoC has to prevent homelessness among people transitioning from prisons, jails, or court-ordered programs.

(limit 500 characters)

The CoC partners w/ parole offices, THRIVE Wellness & Recovery, The Children's Home, & other reentry providers to prevent homelessness among individuals exiting incarceration. Through coordinated reentry planning, housing placements & supportive services, participants are connected to stable housing, behavioral health care, employment resources, & community supports. THRIVE & other partners provide housing opportunities that help ensure successful reintegration & reduce the risk of homelessness.

1C-17. Collaboration with Partners to Address High Utilizers of Healthcare Systems.

Identify at least one partnership or project your CoC has to provide specialized supportive services for homeless individuals with a high level of medical needs.

(limit 500 characters)

The CoC partners with North Country Family Health Center to support individuals experiencing homelessness with complex medical and behavioral health needs. Clients access primary care, behavioral health services, dental care, preventive services, and case management. This partnership improves access to care, supports ongoing treatment, reduces emergency service use, and promotes better health outcomes and housing stability.

1C-18. Collaboration with Partners to Address the Needs of Aging and Elderly Individuals Experiencing Homelessness.

Identify at least one partnership or project your CoC has to serve aging and elderly individuals experiencing homelessness, such as with a provider of residential care, assisted living, or medical respite services.

(limit 500 characters)

While the CoC does not currently have any CoC funded projects dedicated to serving the aging and elderly, 522 CoC Membership features St. Lawrence, Lewis, and Jefferson County Department of Social Services who works closely with Adult Protective Services (APS). APS streamlines referrals, offers case management, long term planning, benefits assistance and housing assistance. The CoC will work to recruit further partnerships to address aging and elderly individuals experiencing homelessness.

1C-19. Permanent Supportive Housing for Chronically Homeless Individuals and Families—Project that Prioritizes Individuals Experiencing Chronic Homelessness.

Identify at least one Rapid Rehousing (RRH) or Permanent Supportive Housing (PSH) project that prioritizes individuals experiencing chronic homelessness.

(limit 500 characters)

Within the NY-522 CoC, Jefferson County Department of Social Services operates both the PSH Chronic and the PSH project, both PSH projects that prioritize individuals experiencing chronic homelessness. Thrive Wellness and Recovery also operates a PSH Chronic program that prioritizes individuals experiencing chronic homelessness.

1C-19a. Permanent Supportive Housing for Chronically Homeless Individuals and Families—On-site Behavioral Healthcare.

Describe how the project(s) identified in 1C-19 provides on-site behavioral healthcare.

(limit 2,500 characters)

Jefferson County Department of Social Services' PSH Chronic and PSH projects and Thrive Wellness and Recovery's PSH Chronic project prioritizes those experiencing chronic homelessness but does not provide on-site behavioral healthcare services. However, these programs work with partners in the community to connect program participants with behavioral health services to support housing stability, overall wellness, and successful community integration for program participants.
The programs connect clients to behavioral healthcare services that include mental health, substance use, and peer recovery support. In the future, the CoC will work to encourage that services are delivered at the project site, allowing participants to receive care in a familiar environment, removing barriers to participation.
Through community connection, behavioral healthcare services are tailored to the individual needs of each participant. Staff work collaboratively with participants to address behavioral health needs, barriers to housing stability, and long-term recovery goals. Regular communication among service providers helps ensure participants receive comprehensive support and timely interventions when needed.
Through the integration of housing and behavioral healthcare services, Jefferson County DSS and Thrive Wellness and Recovery helps participants address behavioral health challenges, maintain stable housing, and progress toward their individual goals.

1C-19b. Permanent Supportive Housing for Chronically Homeless Individuals and Families—Assesses Need for Higher Level of Care.

Describe how the project(s) identified in 1C-19 has a policy for assessing program participant need for higher level of care (i.e., assisted living, residential treatment).

(limit 2,500 characters)

Jefferson County Department of Social Services' PSH Chronic and PSH projects and Thrive Wellness and Recovery's PSH Chronic project prioritizes those experiencing chronic homelessness and assesses participants' needs for a higher level of care as part of ongoing case management and service planning. Project staff assess housing stability, activities of daily living, behavioral health, medical needs, safety concerns, and the participant's ability to live independently. When an assessment indicates that a participant may require a higher level of care, staff work with the participant to identify appropriate services and make referrals to qualified community-based providers, such as assisted living, residential treatment, behavioral health, medical, or other supportive care programs. Referrals are coordinated with the participant and appropriate service providers, with participant consent and in accordance with applicable privacy requirements. The participant's needs and progress are reviewed on an ongoing basis, and service plans are adjusted when a higher or different level of care is identified as necessary.

1C-19c. Permanent Supportive Housing for Chronically Homeless Individuals and Families—Assesses Readiness for Moving On.

Describe how the project(s) identified in 1C-19 has a policy for assessing program participant readiness for moving on to unsubsidized or other permanent housing.

(limit 2,500 characters)

The NY-522 CoC's policy for assessing participant readiness for moving on to unsubsidized or other permanent housing is outlined in the CoC's Move On Strategy which is noted in the CoC's Written Standards. The strategy is designed to promote tenant independence, self-sufficiency, and housing choice while ensuring that supportive housing resources remain available for households with the highest needs.

As CoC-funded projects, Jefferson County Department of Social Services' PSH Chronic and PSH and Thrive Wellness and Recovery's PSH Chronic follows the CoC's approved Move On Strategy to assess whether participants are ready to transition from permanent supportive housing to unsubsidized housing or other permanent housing options. Through ongoing case management, project staff regularly meet with participants to establish goals, evaluate progress, and support housing stability using a strength-based and recovery-focused approach. Participants are informed that moving on is voluntary and driven by client choice. Housing providers evaluate whether participants have demonstrated the ability to maintain stable housing, meet the screening requirements of affordable housing providers or public housing authorities, and sustain a level of independence that no longer requires intensive supportive housing services.

The Move On Strategy requires providers to assess multiple areas related to housing stability and independence, including emotional readiness and confidence to move, financial capacity and budgeting skills, employment or income stability, housing history, service utilization, health and behavioral health management, connection to mainstream resources, natural support systems, community living skills, activities of daily living, and long-term housing goals. Program staff use these factors to evaluate tenant capacity, motivation, confidence, and overall readiness for a successful transition on a regular basis. For participants who express interest in moving on, staff work collaboratively with the household to create a formal transition plan that identifies strengths, needed supports, and steps toward securing permanent housing. Participants are connected to resources such as employment supports, benefits counseling, community-based services, and housing search assistance. The project also provides transition supports, including assistance locating and securing housing, landlord engagement, linkage to community resources, and ongoing case management.

1D. Project Capacity, Review, and Ranking–Local Competition

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- Frequently Asked Questions

1D-1.	Project Review and Ranking Process Your CoC Used in Its Local Competition. We use the response to this question along with the required attachment as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria below.	

You must upload the Local Competition Scoring Tool attachment to the 4A. Attachments Screen.
Select 'Yes' or 'No' in the chart below to indicate how your CoC reviewed, rated, and ranked project applications during your local competition:

1.	Established total points available for each project application type.	Yes
2.	At least 50 percent of the total available points were based on objective criteria to review, rate, and rank project applications.	Yes
3.	At least 25 percent of the total available points were based on system performance measures to review, select and rate project applications.	Yes
4.	Considered returns to homelessness in reviewing, rating, and ranking housing projects (TH, PH-PSH, PH-RRH).	Yes
5.	Considered employment income in reviewing, rating, and ranking housing projects (TH, PH-PSH, PH-RRH).	Yes
6.	Considered supportive service participation requirements in reviewing, rating, and ranking housing projects (TH, PH-PSH, PH-RRH).	Yes

1D-2.	New Proposals.	
	Does your CoC invite new proposals from entities that have not previously received funding, if such eligible entities exist?	Yes

1D-2a.	Web Posting of CoC-Approved Consolidated Application Before the CoC Program Competition Application Submission Deadline.	

	Enter the date your CoC posted all parts of the CoC-approved Consolidated Application on the CoC's website or partner's website–which included: 1. the CoC Application, and 2. Project Priority Listings.	09/28/2026

1D-2b.	Notification to Community Members and Key Stakeholders by Email that the CoC-Approved Consolidated Application is Posted on the Website.	

	Enter the date your CoC notified community members and key stakeholders that the CoC-approved Consolidated Application was posted on your CoC's website or partner's website.	09/28/2026

1D-2c.	Local Competition Selection Results for All Projects.	
	You must upload the Local Competition Selection Results attachment to the 4A. Attachments Screen.	

	Does your attachment include: 1. Project Names, 2. Project Scores, 3. Project Rank, 4. Project Status–Accepted, Rejected, Reduced Reallocated, Fully Reallocated, 5. Amount Requested from HUD, and 6. Reallocated Funds +/-.	Yes

1D-2d.	Projects Rejected/Reduced–Notification Outside of e-snaps.	

1.	Did your CoC reject or reduce any project application(s) submitted for funding during its local competition?	Yes
2.	If you selected 'Yes' for element 1 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.	07/29/2026
3.	Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?	Yes

1D-2e.	Projects Accepted–Notification Outside of e-snaps.	

	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	07/29/2026

1D-3.	Reallocation–Reviewing Performance of Existing Projects.	

	Describe:
1.	your CoC's reallocation process to reallocate from lower performing projects to create new high performing projects, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed,
2.	whether your CoC identified any low performing or less needed projects through the process described in element 1 of this question during your CoC's local competition this year,
3.	whether your CoC reallocated any low performing or less needed projects during its local competition this year; and
4.	why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable.

(limit 2,500 characters)

The CoC determines candidates for reallocation due to low performance or less-needed projects as a tool to make strategic improvements to the homeless system. 1) The reallocation process starts with UFA Fiscal monitoring, as required by the UFA Standard Operating Procedure (SOP). The Fiscal Committee regularly reviews expenditure percentages and SOP benchmarks to ensure funds will be spent, identifies projects with a history of inadequate financial management or recaptured funds, and recommends reallocation of poor-performing projects to the Board. The Review Team flags projects demonstrating ongoing poor performance outcomes or consistently low Rank & Review scores. The Board makes the final decision to reallocate funding to create a new high-performing project based on project performance outcomes, populations served, and community need, and shares its decision with CoC Membership. If a project is considered needed in the community, such as one uniquely serving a hard-to-serve population, the Board works with the Collaborative Applicant to provide TA to address underperformance. If reallocation would better serve people experiencing homelessness, funding is made available through the new project Rank & Review process. A separate application is required for projects developed with reallocated funds, which must fill an unmet need, and applications are accepted alongside renewal applications for Rank & Review.
For FY26, the CoC did not identify any low-performing or less-needed projects through UFA Fiscal monitoring, the Review Team process, or Rank & Review. High project performance was demonstrated through these reviews, and projects continue to address identified community needs. As no low-performing or less-needed projects were identified, the CoC did not reallocate any projects or funding during the local competition. Through the local competition, the CoC determined that all projects are high performing and fulfilling identified community needs; therefore, reallocation was not necessary.

1D-3a.	**Reallocation Between FY 2021 and FY 2026.**	

	Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2021 and FY 2026?	Yes

2A. Homeless Management Information System (HMIS) and System Performance

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

2A-1.	HMIS Vendor.	
	Not Scored–For Information Only	

	Enter the name of the HMIS Vendor your CoC is currently using.(limit 75 characters)	Foothold

2A-2.	HMIS Implementation Coverage Area.	
	Not Scored–For Information Only	

	Select from dropdown menu your CoC's HMIS coverage area.	Multiple CoCs

2A-3.	PIT Count–Methodology Change.	

	Describe:
1.	any changes your CoC made to your unsheltered PIT count implementation, including methodology or data quality changes between 2025 and 2026, if applicable, and
2.	how the changes affected your CoC's PIT count results.

(limit 2,500 characters)

The CoC implemented data quality actions, including increased training of volunteers to improve the validity of the unsheltered PIT count. No methodology changes were made. The unsheltered PIT count was improved through increased/improved training to ensure de-duplication and effective interview techniques. As a result of the increased/improved training in 2026, the CoC was able to administer a more accurate unsheltered PIT count which indicated a decrease from 15 in 2025 to 13 in 2026.

2A-4. Reduce Encampments—Actions to Reduce Encampments.

Describe in the field below the actions your CoC took to reduce the number of encampments or the number of people residing in encampments during your evaluation period.

(limit 2,500 characters)

During the evaluation period, the Continuum of Care (CoC) collaborated with local governments, homeless service providers, street outreach teams, and community partners to address unsheltered homelessness and reduce encampments. Efforts focused on connecting individuals with emergency shelter, housing interventions, and supportive services while addressing barriers to housing stability. The CoC supported street outreach efforts to identify and engage individuals residing in encampments, assess their needs, develop individualized housing plans, and facilitate referrals to emergency shelter, coordinated entry, and other homeless assistance programs. Through coordinated entry, individuals were connected to appropriate housing interventions based on their needs and program eligibility, including permanent supportive housing, rapid rehousing, transitional housing, and other available resources. The CoC also monitored local laws and ordinances affecting camping and encampments throughout its geographic area to remain informed of changes impacting individuals experiencing unsheltered homelessness. This monitoring supported communication and coordination between homeless response partners and local jurisdictions regarding outreach, service delivery, and housing placement efforts. Ongoing collaboration among participating agencies helped identify service gaps, address barriers to housing, coordinate available resources, and strengthen the community's response to unsheltered homelessness. To improve its ability to measure and respond to unsheltered homelessness, the CoC will implement the collection and entry of encampment-related data into the Homeless Management Information System (HMIS). This initiative will support more accurate documentation of encampments and the individuals residing in them, facilitate monitoring of trends and changes over time, and improve understanding of the population's needs. More consistent data will inform resource allocation, strengthen outreach coordination, and help evaluate the effectiveness of encampment reduction strategies The CoC remains committed to strengthening partnerships, improving outreach and coordinated entry processes, enhancing data collection, and expanding access to housing and supportive services to reduce encampments and improve outcomes for individuals experiencing unsheltered homelessness.

2A-4a.	Reduce Encampments—Number of Encampments.	

1. Enter the estimated number of encampments in the beginning of your evaluation period.	4
2. Enter the reduction in the number of encampments during your evaluation period.	2

2A-4b.	Reduce Encampments—Number of People in Encampments.	

1. Enter the estimated number of people in encampments in the beginning of your evaluation period.	31
2. Enter the reduction in the number of people in encampments during your evaluation period.	16

2A-4c.	Reduce Encampments—Plans to Reduce Encampments.

If there has been no reduction in encampments or persons in encampments in your CoC, describe the plans your CoC has to participate in efforts to reduce these numbers.

(limit 2,500 characters)

N/A

2A-5. Reducing the Number of First Time Homeless–CoC's Plan.

Describe your CoC's plan to decrease the number of individuals and families becoming homeless for the first time.

(limit 2,500 characters)

The CoC continues to develop its process to determine risk factors used to identify persons that may become homeless for the first time. The process includes analyzing HMIS, LSA, Stella, SPMs, & CE data, & hosting community discussions to identify risk factors for becoming homeless for the first time. The CoC Board is responsible for reviewing HMIS, LSA, Stella, SPMs, & CE data to identify & consider characteristics of those who are first-time homeless, including demographics, cause of homelessness, & disabling conditions. The CoC identifies common factors contributing to first-time homelessness through community conversations & CE case conferencing w/ prevention providers, emergency shelters, Dept. of Social Services, & faith-based leaders. This qualitative information supplements HMIS data to create a holistic picture of local causes of first-time homelessness. The CoC has developed four strategies to address individuals & families at risk of becoming homeless for the first time. These strategies include a) to educate community providers who serve vulnerable populations (i.e. hospitals, prevention providers, food pantries, health clinics) about risk factors & newly developed CE prevention referral protocols to support those individuals & families; b) to communicate risk factors for first time homelessness identified through data analysis with CE- the CE committee utilizes this info to continually update the CE vulnerability index w/characteristics associated with first time homelessness; c) to increase the amount of prevention funding available in the community on an ongoing basis (i.e. HOME-ARP), an essential component of increasing the number of individuals & families able to remain stably housed, preventing new episodes of homelessness; & d) advocating to NYS for affordable housing development through HOME-ARP funds

2A-6. Reducing Length of Time Homeless–CoC's Plan.

Describe your CoC's plan to reduce the length of time individuals and families remain homeless.

(limit 2,500 characters)

The CoC's strategy to reduce the length of time (LOT) individuals and families remain homeless includes: a) increasing the number of affordable housing options through advocacy for affordable housing development and engaging systems of care to provide and increase units of homeless and affordable housing (DV, Mental Health, PHAs, etc.) and engaging landlords in the multi-county region to rent to tenants using subsidies; b) ensuring CoC and program policies remove systemic barriers to rapid housing & c) coordinating housing opportunities through the Coordinated Entry (CE) program. The CoC routinely supports the increase of permanent housing options with letters of support and data demonstrating need. For example, the CoC supported NYS Empire State Supportive Housing Initiative (ESSHI) applications for PSH; is partnering with the State to implement HUD's Emergency Housing Voucher (EHV); and is implementing its Moving On Strategy to ensure PSH units are available for the hardest to serve. Additionally, the CoC's System Committee has worked to educate landlords on housing subsidy programs and code enforcement regulations to increase the number of landlords with quality units willing to prioritize households with rental assistance. The CoC identifies, prioritizes, and houses individuals and families with the longest LOT homeless through the CE program. During bi-weekly CE case conferencing, staff discuss barriers to housing persons who have remained homeless the longest. The CE Committee develops creative/alternative solutions to finding the most immediate/appropriate housing for these households. The CE system works to reduce LOT homeless by including LOT as a prioritizing criterion within the CE's prioritization process. The CoC also engages non-CoC-funded housing providers (e.g. OMH Housing) to increase the number of appropriate housing options for those coming through CE. The CoC also collaborates with affordable housing developers who then work with support services agencies in the CoC to provide PSH. Together, these strategies result in an increase in immediate housing opportunities for those who are homeless.

2A-7.	**Successful Permanent Housing Placement–Exits to Unsubsidized Housing.**	

Based on HMIS data, what percent of program participants exited from TH/RRH/PSH collectively to unsubsidized housing?	55.00%

Describe how you calculated the data for this response.

(limit 2,500 characters)

The information was generated from the CARES Collaborative HMIS Database for the reporting period of October 1, 2024, through September 30, 2025. Reporting Methodology and Parameters: Using the HMIS Report Builder module, a report was generated for the entire Continuum of Care (CoC) identifying clients who exited Transitional Housing, Rapid Re-Housing, or Permanent Supportive Housing projects during the applicable reporting period. The percentage of exits to unsubsidized housing was calculated using the total number of exit destinations recorded in HMIS Data Element 3.12. The following exit destinations were included in the calculation: 1) Staying or living with family, permanent tenure 2) Staying or living with friends, permanent tenure 3) Rental by client, no ongoing housing subsidy 4) Owned by client, no ongoing housing subsidy. Exit destinations other than the four categories listed were excluded from the numerator when calculating the percentage of exits to unsubsidized housing. However, all exit destinations recorded in HMIS Data Element 3.12 were included in the denominator.

2A-8.	Housing Inventory Count (HIC) and Point-in-Time (PIT) Count Date.	

	Enter the date your CoC conducted its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count.	01/26/2026

2A-8a.	HIC and PIT Count Data–HDX 2.0 Submission Date.	

	Did your CoC submit its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count data in HDX 2.0 by April 30, 2026, 8:00 p.m. EDT?	Yes

2A-8b.	Longitudinal System Analysis (LSA) Data–HDX 2.0 Submission Date.	
	You must upload your CoC's FY 2026 HDX Competition Report to the 4A. Attachments Screen.	

	Did your CoC submit at least two usable LSA data files to HUD in HDX 2.0 by January 16, 2026, 11:59 p.m. EST?	Yes

2A-8c.	System Performance Measures (SPM) Data–HDX 2.0 Submission Date.	

	Did your CoC submit its FY 2025 System Performance Measures data in HDX 2.0 by March 4, 2026, 8:00 p.m. EDT?	Yes

2A-9.	HMIS and Comparable Database Participation—Bed Coverage Rate.	

Using the FY 2026 HDX Competition Report we issued your CoC, enter data in the chart below by project type:

Project Type	Adjusted Total Year-Round, Current Non-VSP Beds	Adjusted Total Year-Round, Current VSP Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS Comparable Database	HMIS and Comparable Database Coverage Rate
1. Emergency Shelter (ES) beds	44	24	68	100.00%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	14	0	14	100.00%
4. Rapid Re-Housing (RRH) beds	150	0	150	100.00%
5. Permanent Supportive Housing (PSH) beds	426	0	367	86.50%
6. Other Permanent Housing (OPH) beds	0	0	0	0.00%

2A-9a.	Partial Credit for Bed Coverage Rates of 84.99 Percent or Lower for Any Project Type in Question 2A-9.	

	For each project type with a bed coverage rate that is 84.99 percent or lower in question 2A-9, describe:
1.	steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type, and
2.	how your CoC will implement the steps described to increase bed coverage to at least 85 percent.

(limit 2,500 characters)

N/A

3A. Policy Initiatives

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- Frequently Asked Questions

3A-1.	**Supporting Activities within an Opportunity Zone.**	
	You must upload the HUD-2996 Certification for Opportunity Zone Preference Points attachment to the 4A. Attachments Screen.	

1.	**Will the proposed activities/projects occur within Opportunity Zone Census Tracts?**	Yes
2.	**Do you expect to use at least 50% of the proposed activities/projects in Opportunity Zones Census Tracts?**	Yes

3A-2	**Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.**

Is your CoC requesting to designate one or more of its SSO, TH, or Joint TH and PH-RRH component projects to serve families with children or youth experiencing homelessness as defined by other Federal statutes? No

Submission Summary

Ensure that the Project Priority List is complete prior to submitting.

Page	Last Updated
1A. CoC Identification	09/25/2026
1B. Coordination and Engagement–Accountable Structure and Participation	09/30/2026
1C. Coordination and Engagement	09/30/2026
1D. Project Review/Ranking	09/30/2026
2A. HMIS Implementation	09/25/2026
3A. Policy Initiatives	09/25/2026
Submission Summary	No Input Required